

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint Number: IN00184757 Substantiated; No deficiencies related to the allegations are cited.</p> <p>Facility Number: 005068</p> <p>Date of Survey: 10/19/2015</p> <p>Community Hospital East is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: cjl 12/04/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE